

# POLICY AND PROCEDURE

POLICY NUMBER: RX.PA.099.E

REVISION DATE: 8/13
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POLICY TITLE: 5-HT3 Antagonist Step Therapy

DEPARTMENT: Clinical Pharmacy Services- Utilization Management
ORIGINAL DATE: January 2009 (as adopted from UPMC Health Plan)

Last P & T Committee Approval Date: February 2018

Product Applicability: mark all applicable products below:

COMMERCIAL	[]HMO	[]PPO	Products: [ ] Small [ ] Indiv. [ ] Large	Exchange: [ ] Shop [ ] Indiv.	[x] All
OTHER	[x]Self-f	unded/ASC	)		

### **PURPOSE**

The purpose of this policy is to define the prior authorization process for 5-HT3 antagonist step therapy.

Oral ondansetron (Zofran®) is the preferred 5-HT3 antagonist for Commercial members. Coverage of all other 5-HT3 antagonists is dependent upon previous trial and failure of ondansetron (Zofran).

### **DEFINITIONS**

**5-HT3 Receptor** – subtype 3 of the ligand-gated ion channels that are activated by serotonin and located in the central and peripheral nervous system. These receptors are involved in mediation and modulation of neurotransmitter release and are targeted by 5HT3-antagonists in the treatment of nausea and vomiting.

# **POLICY**

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, as defined in CRM.015-Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.003-Prior Authorization Process.

The formulary 5-HT3-antagonist medications are subject to the prior authorization process.



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### **PROCEDURE**

### **Initial Authorization Criteria:**

Must meet all of the criteria listed under the respective header:

- The criterion for automatic coverage of oral and transdermal 5-HT3 antagonists is as follows:
  - Must have a documented pharmacy claim history of prior therapy with oral ondansetron (Zofran)
- For members without a documented claim history of oral ondansetron (Zofran), a medical necessity review is completed and the following criterion must be submitted:
  - Chart documentation which shows the member has tried and failed or has an intolerance or contraindication to oral ondansetron (Zofran).

# **Limitations:**

Length of Authorization (if above criteria met)				
Initial Authorization	Up to duration of member's membership with plan			
Reauthorization	N/A			

If the established criteria are not met, the request is referred to a Medical Director for review.

### **REFERENCES**

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- 6. Ondansetron hydrochloride (Zofran tablets, ODT, and oral solution) [package insert]. GlaxoSmithKline. February 2006.
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- National Comprehensive Cancer Network (NCCN). Clinical practice guidelines in oncologyantiemesis. Version 3.2008. Accessed on 9/22/2008. Available at http://www.nccn.org/professionals/physician\_gls/PDF/antiemesis.pdf
- 12. Gan TJ, Meyer T, Apfel, CC, et al. Consensus Guidelines for Managing Postoperative Nausea and Vomiting. *Anesth Analg.* 2003;97(1):62-71.
- 13. Jordan K, Sippel C, Schmoll HJ. Guidelines for Antiemetic Treatment of Chemotherapy-Induced Nausea and Vomiting: Past, Present, and Future Recommendations. *The Oncologist.* 2007;12:1143-1150.
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# **RECORD RETENTION**

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

# **REVIEW HISTORY**

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual Review	02/17, 02/18

